

New Patient History - Optimum Health Family Practice
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Name _____ DOB _____ Age _____ Date _____

Occupation: _____

1. Please list all **medications** taken regularly, dosage, and length of time each has been used. Include over-the-counter medications, vitamins, aspirin, birth control pills, antacids, nasal sprays, eye drops, injections, and skin medications. Use additional sheet if necessary:

Medication/Dosage	Frequency	Years/months taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Have you had any of the following? (please circle)
Diabetes, heart disease, cancer, emphysema, bronchitis, tuberculosis, migraine, gout, colon polyps or disease, stroke, kidney disease, gallbladder disease, high blood pressure, vascular disease, neurological disease, serious infection

3. Please list all past operations, hospitalizations, broken bones, serious illnesses, and allergies:

	Year	Reason or Problem
Hospitalizations and surgeries	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
Other illnesses or problems	_____	_____
	_____	_____
	_____	_____
	_____	_____
Drug allergies or reactions (include med. name)	_____	_____
	_____	_____

*Do you see any other doctors or specialist? _____

4. **Vaccinations and childhood diseases:**
 Please list approximate year of last vaccination or year of illness for the following – if known:
 Td/Tdap: _____ Pneumovax (pneumonia vaccine): _____
 Flu vaccine: _____ Zostavax (shingles vaccine): _____

6. **Screening tests:** If you've had any of the following tests, please note the year last performed (if known):
 Lipids (cholesterol): _____ Urinalysis: _____ Glucose: _____ PSA: _____
 Stools for blood: _____ Colonoscopy: _____ Mammogram: _____ EKG: _____
 Pap smear: _____ Treadmill EKG: _____ Bone mineral density: _____

7. What else should we know about you? _____

8. Family medical history: Not Adopted / Adopted (if adopted skip family history section)

Is there any family history of (please circle): *Ulcers, tuberculosis, alcoholism, heart disease, cancer, stroke, diabetes, emphysema, high blood pressure, high cholesterol, kidney disease, colon polyps, colon cancer, Alzheimer's disease, congenital disorders, or other serious illness.*

	Living?	Age(s) now or age at death	Significant medical problems and/or cause of death
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Brothers	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Sisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Sons	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Daughters	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
<u>Grandparents</u>			
Maternal GF	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Maternal GM	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Paternal GF	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Paternal GM	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

Uncles and aunts with significant diseases:

Yes No

Have you ever smoked? If yes, total years you have smoked? _____

Yes No

Do you smoke now? If yes, number of cigarettes a day? _____ Packs a day? _____

Number of cigars a day? _____ Ounces of pouches a week (pipe)? _____

Yes No

Do you chew tobacco or use snuff? If yes, how much? _____

If you have quit tobacco (chewing or smoking), what year did you quit? _____

Yes No

Do you drink alcohol? If yes, how many ounces do you drink per day or week of:

Liquor? _____ oz/day or week; Wine? _____ oz/day or week; Beer? _____ oz/day or week

If you have quit drinking alcohol, when did you quit? _____

Have you ever been counseled for alcohol or drug abuse? Yes No

Yes No

Do you or have you in the past regularly used marijuana, cocaine, amphetamines, or any other mind-altering drugs?

Please specify: _____

Yes No

Do you have a regular exercise program? If yes, how often do you exercise per week? _____

How many minutes do you exercise per session on average? _____

Yes No

Do you get exercise at work? Please describe any regular exercise: _____

Yes No

Do you wear **seat belts** in the car? always sometimes never Airbags in the vehicle?

Yes No

Do you floss your teeth regularly? When was your last dental exam? _____

Yes No

Have you ever had any **exposure to known toxins**, cancer-causing substances (carcinogens), or known hazardous materials? If yes, list materials _____

Yes No

Do you participate in any **dangerous hobbies** or activities?

Occupational history: Please list all jobs you have held in adult life and number of years worked:

Yes No

Do you have **smoke alarms** in your home?

Yes No

Do you have risk factors for hepatitis or HIV? (i.e. multi-sexual partners, tattoos, drug use with needles, work exposure to blood, other).

What is your **current level of motivation** to maintain and improve your health? High Medium Low (circle)

What is your **worst habit** affecting your health? _____

Reviewed by: _____